Cabinet for Health and Family Services
Department for Medicaid Services
Frankfort KY 40621

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Medicaid Nursing Facility Services Manual
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KENTUCKY MEDICAID PROGRAM
NURSING FACILITY SERVICES
MANUAL

Cabinet for Health and Family Services
Department for Medicaid Services
Division of Long Term Care and Community Alternatives
Frankfort, Kentucky 40621

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I. INTRODUCTION

A. Introduction

The Kentucky Medicaid Program Nursing Facility Services Manual provides Medicaid providers with a tool to be used when providing services to qualified Medicaid recipients. This manual provides basic information concerning coverage and policy. Precise adherence to policy shall be imperative.

B. Fiscal Agent

The Department for Medicaid Services contracts with a fiscal agent for the operation of the Kentucky Medicaid Management Information System (MMIS). The fiscal agent receives and processes all claims for medical services provided to Kentucky Medicaid recipients.

C. General Information

The Department for Medicaid Services shall be bound by both Federal and State statutes and regulations governing the administration of the State Plan. The state shall not be reimbursed by the federal government for monies improperly paid to providers for non-covered, unallowable medical services. Therefore, Kentucky Medicaid may request a return of any monies improperly paid to providers for noncovered services.

KENTUCKY MEDICAID PROGRAM
NURSING FACILITY SERVICES MANUAL

SECTION II – COMMONWEALTH OF KENTUCKY MEDICAID PROGRAM

II. COMMONWEALTH OF KENTUCKY MEDICAID PROGRAM

A. Policy

The basic objective of the Kentucky Medicaid Program shall be to ensure the availability and accessibility of quality medical care to eligible program recipients.

The Medicaid Program shall be the payor of last resort. If the recipient has an insurance policy, veteran's coverage, or other third party coverage of medical expenses, that party shall be primarily liable for the patient's medical expenses. Accordingly, the provider of service shall seek reimbursement from the third party groups for medical services provided prior to billing Medicaid. If a provider receives payment from a recipient, payment shall not be made by Medicaid. If a payment is made by a third party, Medicaid shall not be responsible for any further payment above the Medicaid maximum allowable charge.

In addition to statutory and regulatory provisions, several specific policies have been established through the assistance of professional advisory committees. Principally, some of these policies are as follows:

All participating providers shall agree to provide medical treatment according to standard medical practice accepted by their professional organization and to provide Medicaid-covered services in compliance with federal and state statutes regardless of age, color, creed, disability, ethnicity, gender, marital status, national origin, race, religion, or sexual orientation.

Provider shall comply with the Americans with Disabilities Act and any amendments, rules, and regulations of this Act.

Each eligible medical professional shall be given the choice of whether or not to participate in the Kentucky Medicaid Program in accordance with 907 KAR 1:672. From those professionals who have chosen to participate, recipients may select the provider from whom they wish to receive their medical care.

If the Department makes payment for a covered service and the provider accepts this payment in accordance with the Department's fee structure, the amounts paid shall be considered payment in full; a bill for the same service shall not be tendered to the recipient, and a payment for the same service shall not be accepted from the

recipient. The provider may bill the recipient for services not covered by Kentucky Medicaid.

Providers of medical service or authorized representatives attest by their signatures, that the presented claims are valid and in good faith. Fraudulent claims shall be punishable by fine, imprisonment or both. Facsimiles, stamped or computer generated signatures shall not be acceptable.

The recipient's Kentucky Medical Assistance Identification Card should be carefully checked to see that the recipient's name appears on the card and that the card is valid for the period of time in which the services are to be rendered. If there is any doubt about the identity of the recipient, you may request a second form of identification. A provider can not be paid for services rendered to an ineligible person. Failure to validate the identity of a Medicaid recipient prior to a service being rendered may result in failure to comply with 907 KAR 1:671. Any claims paid by the Department for Medicaid Services on behalf of an ineligible person may be recouped from the provider.

The provider's adherence to the application of policies in this manual shall be monitored through either on-site audits, postpayment review of claims by the Department, or computer audits or edits of claims. When computer audits or edits fail to function properly, the application of policies in this manual shall remain in effect. Therefore, claims shall be subject to postpayment review by the Department.

All providers shall be subject to rules, laws, and regulations issued by appropriate levels of federal and state legislative, judiciary and administrative branches.

All services provided to eligible Medicaid recipients shall be on a level of care that is equal to that extended private pay individuals or others, and on a level normally expected of a person serving the public in a professional capacity.

All recipients shall be entitled to the same level of confidentiality afforded persons NOT eligible for Medicaid benefits.

Claims shall not be allowed for services outside the scope of allowable benefits within a particular program specialty. Likewise, claims shall not be paid for services that required and were not granted prior authorization by the Kentucky Medicaid Program. In addition, providers are subject to provisions in 907 KAR 1:671, 907 KAR 1:672, and 907 KAR 1:673.

Claims shall not be paid for medically unnecessary items, services, or supplies. The recipient may be billed for non-covered items and services. Providers shall notify recipients in advance of their liability for the charges for non-medically necessary and non-covered services.

If a recipient makes payment for a covered service, and that payment is accepted by the provider as either partial payment or payment in full for that service, responsibility for reimbursement shall not be attached to the Department and a bill for the same service shall not be paid by the Department. However, a recipient with spend down coverage may be responsible for a portion of the medical expenses they have incurred.

B. Appeal Process for Refund Requests

Inappropriate overpayments to providers that are identified in the postpayment review of claims shall result in a refund request.

If a refund request occurs subsequent to a postpayment review by the Department for Medicaid Services or its agent, the provider may submit a refund to the Kentucky State Treasurer or appeal the Medicaid request for refund in writing by providing clarification and documentation that may alter the agency findings. This information relating to clarification shall be sent to :

DIVISION OF LONG TERM CARE AND COMMUNITY
ALTERNATIVES
DEPARTMENT FOR MEDICAID SERVICES
CABINET FOR HEALTH AND FAMILY SERVICES
275 EAST MAIN STREET
FRANKFORT KY 40621

If no response (refund or appeal) has been filed with Medicaid by the provider within thirty (30) days of the refund request, assent to the findings shall be assumed. If a refund check or request for a payment plan is not received within sixty (60) days, Medicaid shall deduct the refund amount from future payments.

C. Timely Submission of Claims

According to Federal regulations, claims shall be billed to Medicaid within twelve (12) months of the date of service or six (6) months from the adjudication date of the Medicare payment date or other insurance. Federal regulations define "Timely submission of claims" as received by Medicaid "no later than twelve (12) months from the date of service." Received is defined in 42 CFR 447.45 (d)(5) as follows: "The date of receipt is the date the agency receives the claim, as indicated by its date stamp on the claim." To consider those claims twelve (12) months past the service date for processing, the provider shall attach documentation showing **RECEIPT** by Medicaid, the fiscal agent and documentation showing subsequent billing efforts. Claim copies alone shall not be acceptable documentation of timely billing. Claims shall not be considered for payment if more than twelve (12) months have elapsed between **EACH RECEIPT** of the aged claim by the Program.

Claims should be submitted to:

Unisys Corporation
P.O. Box 2100
Provider Services
Frankfort, KY 40602-2100
1-877-838-5085 – Provider Enrollment
1-800-807-1232 – Provider Assistance

D. Kentucky Patient Access and Care System (KenPAC)]

KenPAC is a statewide patient care system which provides Medicaid recipients with a primary care provider. The primary care provider shall be responsible for providing or arranging for the recipient's primary care and for referral of other medical services. KenPAC recipients shall be identified by a green Medical Assistance Identification (MAID) card.

Medicaid recipients receiving waiver services, as well as nursing facility and Long Term Care services, are exempt from participation in KenPAC.

E. Lock-In Program

The Department shall monitor and review utilization patterns of Medicaid recipients to ensure that benefits received are at an Appropriate frequency and are medically necessary given the condition presented by the recipient. The Department shall investigate all complaints concerning recipients who are believed to be over-utilizing the Medicaid Program.

The Department shall assign one (1) physician to serve as a case manager and one (1) pharmacy. The recipient shall be required to utilize only the services of these providers, except in cases of emergency services and appropriate referrals by the case manager. In addition, providers and recipients shall comply with the provisions set forth in 907 KAR 1:677, Medicaid Recipient Lock-In.

Providers who are not designated at lock-in case managers or pharmacies shall not receive payment for services provided to a recipient assigned to the lock-in program, unless the case manager has pre-approved a referral or for emergency services. Recipients assigned to the lock-in program shall have a pink MAID card and the name of the case manager shall appear on the face of the card.

F. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program

Under the EPSDT program, Medicaid eligible children, from birth through the end of the child's birth month of his twenty-first (21) year, may receive preventative, diagnostic and treatment services by participating providers. The goal of the program is to provide quality preventative health care by performing prescribed screenings at specified time intervals according to age (termed a periodicity schedule) to identify potential physical and mental health problems. These screenings shall include a history and physical examination, developmental assessment, laboratory tests, immunizations, health education and other tests or procedures medically necessary to determine potential problems. Another goal of the program is to reimburse for medically necessary services and treatments, even if the service or treatment is not normally

covered by Kentucky Medicaid. However, the service or treatment must be listed in 42 USC Section 1396 d(a) which defines those services that may be covered by state Medicaid programs. More information regarding the EPSDT program may be obtained by calling the EPSDT program within the Department for Medicaid Services.

G. Kentucky Health Care Partnership Program

In accordance with 907 KAR 1:705, the Department shall implement, within the Medicaid Program, a capitated managed care system for physical health service for persons residing in Region 3 (Shelby, Spencer, Trimble, Wayne, Marion, Meade, Nelson, Oldham, Hardin, Henry, Jefferson, LaRue, Breckinridge, Bullitt, Carroll, and Grayson counties).

Medicaid recipients receiving waiver services, as well as nursing facility and Long Term Care services, are exempt from participation in a capitated managed care system. These recipients receive services through the traditional Medicaid program.

H. EMPOWER Kentucky Transportation Initiative

In accordance with 907 KAR 3:065, the Department shall implement, within the Medicaid Program, as an EMPOWER Kentucky Initiative, a capitated non-emergency medical transportation delivery system excluding ambulatory stretcher services. The Department has entered into a contract with the Transportation Cabinet, along with three other Cabinets, to implement this program incrementally statewide beginning in June 1998. This new system is designed to extend service to areas of the state currently under-served, provide transportation alternatives to more people, encourage efficiency and discourage fraud and abuse.

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SECTION III – CONDITIONS OF PARTICIPATION

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III. CONDITIONS OF PARTICIPATION

A. Participation Overview

Any facility licensed or requesting licensure as a nursing facility by the CABINET FOR HEALTH AND FAMILY SERVICES, Office of Inspector General, Division of Long Term Care, is eligible to submit a Provider Agreement with Addenda I and II, a Disclosure of Ownership and Control, Interest form, and Provider Information form. A facility survey shall then be required to determine that licensure requirements and Kentucky Medicaid Program requirements are being met.

Hospital swing bed facilities providing services in accordance with 42 USC 1395tt and 42 USC 13961 shall also be considered nursing facilities if the swing beds are certified to the Medicaid Program as meeting nursing facility standards. Hospital swing bed facilities are currently exempt from the PreAdmission Screening and Resident Review (PASRR) requirement.

Surveys shall take place as often as necessary but at least within fifteen (15) months of the date of the last survey. The MAP 811 shall be submitted annually by a participating facility.

Submission of the required form shall not ensure participation in the Medicaid Program. Participation as a provider shall only be ensured after the agreement is signed by both parties (the provider and the Department for Medicaid Services), proof of the facility's certification to participate in the Medicare Program (Title XVIII) if required is received from the certifying agency, a provider number is issued, and all paperwork involved in the certification process is completed by both parties.

All participating providers shall comply with the requirements specified in 907 KAR 1:671; 907 KAR 1:672; and 907 KAR 1:673.

B. Provider Freedom of Choice

The freedom of choice concept has always been a fundamental principle governing the Kentucky Medicaid Program. Providers shall have the freedom to decide whether or not to accept eligible Medicaid recipients and to bill the Program for the medical care provided.

C. Medicare Participation

All nursing facilities shall have at least twenty (20) percent of all Medicaid certified beds, but not less than ten (10) beds, also certified to participate in Medicare unless they have obtained a Medicaid waiver of the nurse-staffing requirement. If the nursing facility has less than ten (10) beds certified for Medicaid, all Medicaid certified beds shall also be certified to participate in Medicare. If a nursing facility which has obtained a Medicaid waiver of the nurse staffing requirement CHOOSES to participate in Medicare, they shall have at least twenty (20) percent of all Medicaid certified beds, but not less than ten (10) beds, also certified to participate in Medicare; if less than ten (10) beds are certified for Medicaid, all Medicaid certified beds shall also be certified to participate in Medicare.

All nursing facilities shall participate in the Medicare Program (Title XVIII) in order to participate in the Medicaid Program unless they have obtained a Medicaid waiver of the nurse-staffing requirement.

D. Resource Assessment

If a community spouse exists, nursing facilities shall advise each admission, regardless of payer source, of the availability of the resource assessment. The assessment is conducted by the local office of the Department for Community Based Services without cost to the individual. Resource assessments are only completed if a community spouse exists. In order to verify that compliance with this condition has been met, appropriate sections of the MAP-350 form shall be completed by the appropriate parties and a copy retained by the nursing facility in the active clinical record.

E. Out-of-Country Nursing Facilities

Nursing facilities located outside the United States and its territories shall not participate in the Kentucky Medicaid Program except for the purpose of billing Medicare co-insurance amounts for which payment shall be the responsibility of the Kentucky Medicaid Program until the resident is discharged or termination of the resident's QMB and Kentucky Medicaid eligibility.

F. Out-of-State Nursing Facilities

The Kentucky Medicaid Program does not routinely enroll out-of-state nursing facilities except for the purpose of paying Medicare co-insurance amounts for which payment in accordance with

Kentucky Medicaid reimbursement procedures shall be the responsibility of the Kentucky Medicaid Program until the resident is discharged or termination of the resident's QMB and Kentucky Medicaid eligibility.

G. Disclosure of Information (42 CFR 405,420, 431, and 455 and 907 KAR 1:672).

There are requirements for disclosure of information by institutions and organizations providing services under Medicare and Medicaid. The federal and state regulations which relate to disclosure of information are significant and we suggest your attention to them.

OF PARTICULAR IMPACT ON MEDICAID PROVIDERS ARE THE FOLLOWING:

1. The Secretary of the Department of Health and Human Services or the State agency may refuse to enter into or renew an agreement with a provider if any of its owners, officers, directors, agents or managing employees have been convicted of criminal offenses involving any of the programs under Titles XVIII, XIX or XX.

2. The Secretary or State agency may terminate an agreement with a provider that failed to disclose fully and accurately the identity of any of its owners, officers, directors, agents, or managing employees who have been convicted of a program-related criminal offense at the time the agreement was entered into.

3. The Secretary shall have access to Medicaid provider records.

4. Providers shall be required to disclose certain information about owners, employees, subcontractors, and suppliers.

   In addition to these requirements, the federal regulations detail revisions to existing sections on bankruptcy or insolvency and provider agreements, and not information which can be requested concerning certain business transactions.

   The data shall be collected during each provider's certification process by the Division of Long Term Care, Office of the Inspector General.

SECTION III - CONDITIONS OF PARTICIPATION

H. Termination of Participation and Provider Appeals Rights

Termination of a provider participating in the Medicaid Program and the provider's appeal process shall be in accordance with 907 KAR 1:671.

I. Preadmission Screening and Resident Review PASRR

Public Law 100-203, the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) requires that preadmission screening be performed to prevent inappropriate nursing facility admissions of individuals who are mentally ill, mentally retarded, or who have a related condition.

PASRR shall be required for all admissions regardless of payor source in accordance with 907 KAR 1:755.

J. Deposits

In accordance with federal regulations, deposits shall not be required of those persons eligible for Medicaid. Presentation of a current Medical Assistance Identification Card and meeting patient status criteria shall constitute long-term care Medicaid eligibility for services. Any deposits obtained prior to Medicaid eligibility shall be returned to the resident or responsible party when eligibility is determined. Deposits shall be refunded PRIOR TO BILLING the Medicaid Program.

K. Utilization Review

A Peer Review Organization (PRO) shall have Title XIX review responsibility for nursing facility services provided in Kentucky. The PRO is operational Monday through Friday from 8:00a.m. to 6:00 p.m. (Eastern Time), except for holidays.

Professional staff of the Cabinet for Health and Family Services or a PRO operating under its lawful authority pursuant to the terms of its agreement with the Cabinet shall review and evaluate the health status and care needs of an individual in need of inpatient care, giving consideration to the medical diagnosis, age-related dependencies, care needs, services and health personnel required to meet these needs and the feasibility of meeting the needs through alternative institutional or non-institutional services.

Prior to admission of an individual to a nursing facility, the facility must request certification from the PRO. Certification for a new admission of an individual must be requested by the facility within seven (7) working days of the admission. (This seven (7) day time frame is a maximum limit. PRO certification should be requested prior to admission. If an individual is discharged prior to a request for certification, a certification shall not be approved).

If an individual is admitted after normal business hours or on a weekend, request for certification by the PRO may be obtained through use of the MAP-726A. The MAP-726A may be faxed to the PRO at 502-429-5233, 1-800-807-7840, or 1-800-807-8843. Keep a copy of the transmission form generated that indicates the transmission was successful. The nursing facility provider will need this documentation if problems arise concerning the faxed transmission. The MAP-726A may also be used during normal business hours. (A copy of the MAP-726A is located in the Appendix of this manual).

Should a provider admit an individual who does not meet nursing facility level of care certification requirements, DMS will not be responsible for costs associated with individual's care while in the facility. If a provider fails to obtain certification for a resident as outlined above, DMS shall not be responsible for costs associated with that individual's care while in the facility.

In addition, no provision is made in the regulations or manuals for granting retroactive certifications or exceptions. As an entity of state government, the Department for Medicaid Services is obligated to comply with governing regulations. In addition, providers are subject to provisions in 907 KAR 1:671. 907 KAR 1:672, and 907 KAR 1:673.

1. PRO Process for Nursing Facilities: Prior to admission of an individual to a nursing facility, the facility shall request certification of the admission by the PRO. The PRO shall approve the admission and transmit to the facility and the local Department for Community Based Services office a "Confirmation Notice", or deny the admission and issue a

"Denial Letter." The PRO shall submit the Denial Letter to the patient or their responsible party, the physician of record, the facility, and the local Department for Community Based Services office.

If the admission is approved, within thirty (30) days of the admission the PRO shall perform an on site continuing stay review. The PRO shall approve a continued stay if the resident continues to meet the nursing facility level of care criteria in accordance with 907 KAR 1:022. If the resident no longer meets the nursing facility level of care criteria in accordance with 907 KAR 1:022, the PRO shall issue a "Denial Letter".

Specific lengths of stay shall not be assigned for continued stays. The PRO reviewer shall re-certify each resident in the facility every six (6) months, for a continued stay or deny the continued stay. It is the responsibility of the facility to indicate those residents which are to be reviewed by the PRO for continued stay.

It is incumbent upon nursing facilities with a Medicaid waiver of the nurse staffing requirement to discharge the resident when the resident's status changes from nursing facility level of care services to skilled nursing care services during the periods between PRO reviews.

2. PRO Process for Licensed Swing-Bed Nursing Facilities: Prior to admission of an individual to a swing bed nursing facility, or prior to changing the bed from acute care status, if the resident was admitted to the swing bed as an acute care patient, the facility shall request certification by the PRO. The PRO shall approve or deny the admission using the same Department for Medicaid Services criteria as for nursing facilities.

   If the admission is approved, the PRO shall perform an on-site continuing stay review at the end of the initial length of stay (up to thirty (30) days and at least every ninety (90) days thereafter.) The PRO shall approve or deny the continued stay using the same Department for Medicaid Services criteria as for nursing facilities.

If the bed swings to acute for three (3) or more days, the facility shall contact the PRO for review prior to swinging the bed back to nursing facility. When counting the three (3) days, do not count the day the bed will swing back to nursing facility.

Facilities SHALL NOT contact the Medicaid PRO to certify the admission of a Medicaid recipient for whom Medicare Part A shall be the primary payor. Medicare procedures shall be followed for these residents.

When Medicare Part A benefits are exhausted or when the resident no longer meets the level of care criteria for which Medicare shall make reimbursement, whichever comes first, the facility shall request Medicaid certification by contacting the Medicaid PRO.

3. The Medicaid Program is monitoring the PRO determinations on a sample basis. Monitoring shall be for performance assessment only and shall have no bearing on the individual determinations, as all PRO determinations are binding on the Medicaid Program.

L. Distinct Part Certification: Certified Medicaid beds shall be in a distinct part of the facility.

M. Placement: Assistance with placement problems may be obtained by contacting the local office of the Department for Community Based Services whose staff are knowledgeable regarding potential for placement in Kentucky facilities.

N. Nurse Aid Training and Competency Evaluation Program: Nurse Aide Training and Competency Evaluation Program shall be in accordance with regulation 907 KAR 1:450.

KENTUCKY MEDICAID PROGRAM
NURSING FACILITY SERVICES MANUAL

SECTION IV – PROGRAM COVERAGE

SECTION IV - PROGRAM COVERAGE

IV. PROGRAM COVERAGE

A. Recipient Eligibility

QMB and Medicaid eligibility are determined by the local offices of the Department for Community Based Services. Any individual determined to be eligible for Medicaid benefits by the Department for Community Based Services may receive nursing facility benefits if the services have been certified in accordance with Medicaid Program policy.

1. Section 301 of the Medicare Catastrophic Coverage Act of 1988 (MCCA) requires states to provide Medicaid coverage to certain Medicare beneficiaries in order to pay Medicare cost-sharing expenses (premium, deductible and coinsurance amounts). Individuals who are entitled to Medicare Part A and who do not exceed federally-established income and resources standards shall be known as Qualified Medicare Beneficiaries (QMBs).

2. The Technical and Miscellaneous Revenue Act of 1988 (TAMRA) further provides that some individuals shall have dual eligibility for QMB benefits and regular Medicaid benefits.

3. Reimbursement by the Kentucky Medicaid Program for QMB Only and dually eligible individuals and the Medicare-Medicaid (non-QMB) resident includes deductible and coinsurance amounts for all Medicare Part A and Part B covered services.

B. Medical Assistance Identification (MAID) Card

Any individual determined eligible for Medicaid benefits shall be issued a MAID card each month by the Department for Community Based Services. Individuals who have been determined eligible for both Medicaid and QMB benefits shall receive a regular MAID card with a notation on the face of the card that identifies the recipient as being dually eligible, individuals who have been determined to be eligible for QMB benefits only receive a unique tri-colored (red, white, blue) card.

Each card shall indicate the resident's Medicaid number, the month of eligibility, and third party resources (Medicare Part A and Part B, private insurance, etc.) that may be responsible for all or a portion of the resident's cost of care. Acceptance of an outdated card may jeopardize reimbursement to a facility for services provided during the period in question.

C. Authorization

The Medicaid Program shall assume responsibility for provision of financial benefits to nursing facilities on behalf of eligible residents only when specifically authorized by the PRO and the Department for Medicaid Services, as appropriate. The fact that an eligible resident is admitted to a Medicaid certified nursing facility in no way obligates or assures that the Medicaid Program shall make reimbursement for the services or items provided to the resident. This policy shall not dictate the admission policies and procedures for a facility; rather, it merely defines those admissions for which reimbursement shall be made by the Medicaid Program.

D. Determining Patient Status

Professional staff of the Cabinet for Health and Family Services or a Peer Review Organization operating under its lawful authority pursuant to the terms of its agreement with the Cabinet shall review and evaluate the health status and care needs of the resident in need of institutional care, giving consideration to the medical diagnosis, care needs, services and health personnel required to meet those needs and the feasibility of meeting the needs through alternative institutional or non-institutional services. With the exception of those individuals admitted to hospital swing-bed facilities, an individual shall not qualify for Medicaid patient status unless the individual is qualified for admission, and continued stay as appropriate, under the PASRR criteria.

Residents meeting high intensity patient status criteria shall be admitted to beds which are participating in both Medicare and Medicaid. Residents which possess high intensity care needs shall also remain in beds participating in both Medicare and Medicaid after exhaustion of any Medicare benefits.

Insulin-dependent diabetic residents who require at least daily injections which cannot be self-administered may be determined to be either high intensity or low intensity based in part on the attending physician's evaluation. This policy shall not, however, apply to insulin-dependent diabetic residents who have other high intensity conditions.

1. High Intensity Nursing Care (criteria equivalent to skilled nursing care standards under Medicare). Medicaid eligible individuals qualify for high intensity nursing care when their care needs mandate high intensity nursing or high intensity rehabilitation services on a daily basis and when, as a practical matter, the care

can only be provided on an inpatient basis. Where the inherent complexity of a service prescribed for a resident exists to the extent that it can be safely or effectively performed only by or under the supervision of technical or professional personnel, the resident would qualify for high intensity nursing care.

A resident with an unstable medical condition manifesting a combination (two (2) or more) of care needs in the following areas shall qualify for: high intensity nursing care:

(a) Intravenous, intramuscular, or subcutaneous injections and hypodermoclysis or intravenous feeding;

(b) Naso-gastric or gastrostomy tube feedings;

(c) Nasopharyngeal and tracheotomy aspirations;

(d) Recent or complicated ostomy requiring extensive care and self-help training;

(e) In-dwelling catheter for therapeutic management of a urinary tract condition;

(f) Bladder irrigations in relation to previously indicated] [stipulation;

(g) Special vital signs evaluation necessary in the management of related conditions;

(h) Sterile dressings;

(i) Changes in bed position to maintain proper body alignment;

(j) Treatment of extensive decubitus ulcers or other widespread skin disorders;

(k) Receiving medication recently initiated, which requires high intensity observation to determine desired or adverse effects or frequent adjustment of dosage;

(l) Initial phases of a regimen involving administration of

medical gases;

(m) Receiving services which would qualify as high intensity rehabilitation services when provided by or under the supervision of a qualified therapist(s), for example: on-going assessment of rehabilitation needs and potential; therapeutic exercises which must be performed by or under the supervision of a qualified physical therapist; gait evaluation and training; range of motion exercises which are part of the active treatment of a specific disease state which has result in a loss of, or restriction of mobility; maintenance therapy when the specialized knowledge and judgment of a qualified therapist are required to design and establish a maintenance program based on an initial] [evaluation and periodic reassessment of the resident's needs, and consistent with the resident's capacity and tolerance; ultra-sound, short-wave and microwave therapy treatments; hot pack, hydrocollator, infra-red treatment, paraffin baths, and whirlpools (in cases where the resident's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures or other complications, and the skills, knowledge and judgment of a qualified physical therapist are required); and services by or under the supervision of a speech pathologist or audiologist when necessary for the restoration of function in speech or hearing;

2. Low Intensity Nursing Care (criteria equivalent to the former intermediate care patient status standards). Medicaid eligible individuals shall qualify for low intensity patient status when the individual requires, unrelated to age-appropriate dependencies with respect to a minor, intermittent high intensity nursing care, continuous personal care or supervision in an institutional setting. In making the decision as to patient status, the following criteria shall be applicable:

(a) An individual with a stable medical condition requiring intermittent high intensity services not provided in a personal care home shall be considered to meet patient status.

(b) An individual with a stable medical condition, who has a complicating problem which prevents the individual from caring for himself in an ordinary manner outside the institution shall be considered to meet patient status. For example, ambulatory cardiac and hypertensive patients

may be reasonably stable on appropriate medication, but have intellectual deficiencies preventing safe use of self-medication, or other problems requiring frequent nursing appraisal, and thus be considered to meet patient status.

(c) An individual with a stable medical condition manifesting a significant combination (two (2) or more) of the following care needs shall be determined to meet low intensity patient status when professional staff determines that such combination of needs can be met satisfactorily only by the provision of intermittent high intensity nursing care, continuous personal care or supervision in an institutional setting:

(1) Assistance with wheelchair;

(2) Physical or environmental management for confusion and mild agitation;

(3) Must be fed;

(4) Assistance with going to bathroom or using bedpan for elimination;

(5) Old colostomy care;

(6) In-dwelling catheter for dry care;

(7) Changes in bed position;

(8) Administration of stabilized dosages of medication;

(9) Restorative and supportive nursing care to maintain the resident and prevent deterioration of his condition;

(10) Administration of injections during time licensed personnel is available;

(11) Services that could ordinarily be provided or administered by the individual but due to physical or mental condition is not capable of self-care;

(12) Routine administration of medical gases after a regimen of therapy has been established.

(d) An individual shall not generally be considered to meet

patient status criteria when care needs are limited to the following:

1. Minimal assistance with activities of daily living;

2. Independent use of mechanical devices, for example, assistance in mobility by means of a wheelchair, walker, crutch(es) or cane;

3. Limited diets such as low salt, low residue, reducing and other minor restrictive diets;

4. Medications that can be self-administered or the individual requires minimal supervision.]

3. Evaluation of Patient Status for Persons with Mental Disorders or Mental Retardation

Medicaid eligible individuals with a mental disorder or mental retardation meeting high or low intensity care needs as previously defined shall generally be considered to meet patient status. However, these individuals shall be specifically excluded from coverage in the following situations:

(a) If the Cabinet determines that in the individual case the] [combination of care needs are beyond the capability of the facility, and that placement in the facility is inappropriate due to potential danger to the health and welfare of the resident, other patients in the facility, or staff of the facility; and

(b) If the resident does not meet the preadmission screening and resident review criteria specified in 42 USC 1396r for entering or remaining in a facility.

4. Transfer trauma criteria. A Medicaid recipient in an NF who does not meet the low intensity or high intensity nursing care patient status criteria established in Section 4 of 907 KAR 1:022 shall not be discharged from an NF if:
(a) The recipient has resided in an NF for at least eighteen (18) consecutive months;
(b) The recipient's attending physician determines that the recipient would suffer transfer trauma in that his or her physical, emotional or mental well being would be compromised by a

discharge action as a result of not meeting patient status criteria; and
(c) The department confirms the recipient's attending physician's assessment regarding the trauma caused by possible discharge from the NF.

5. A Medicaid recipient who meets transfer trauma criteria in accordance with this Section 4(9) of 907 KAR 1:022 and this section of the manual:
(a) Shall remain in an NF and continue to be covered by the department for provider reimbursement at least until his or her subsequent transfer trauma assessment; and
(b) Be reassessed for transfer trauma every six (6) months.

6. The recipient transfer trauma criteria established in this Section 4(9) of 907 KAR 1:022 and this section of the manual shall not apply to an individual who resides in a facility which experiences closure or a license or certificate revocation.

E. Home- and Community-Based Waiver Program

The Department for Medicaid Services (DMS) requested that the Secretary of the United States Department of Health and Human Services (HHS) exercise his authority under Section 1915(c) of the Social Security Act to grant a waiver of certain federal requirements that would permit Medicaid coverage under the State Plan for a broad array of home and community based services that may be required by the Medicaid recipient who would otherwise require Nursing Facility (NF) level of care. Among the services available under the Home and Community Based Waiver are:

HOME AND COMMUNITY BASED WAIVER

The Home and Community Based (HCB) waiver program was developed to serve Kentucky residents who are aged or disabled as an alternative to placement in a nursing facility (NF). These individuals must meet the level of care criteria for placement in a NF and whose services in a NF would qualify for payment under the State Plan for Medical Assistance. An individual who is an inpatient of a hospital, NF, or Intermediate Care

Facility for the Mental Retarded (ICF/MR) or enrolled in another Medicaid waiver or Medicaid-covered Hospice Program shall be excluded from eligibility.

MODEL WAIVER II

The Model II waiver program was developed to serve Kentucky residents as an alternative to hospital-based nursing facility care for an individual who is ventilator dependent. These individuals must meet the level of care criteria for placement in a nursing facility (NF) and whose services in an NF would qualify for payment under the State Plan for Medical Assistance. Model II waiver services are available to individuals of any age in their homes.

HOMECARE WAIVER

The Homecare waiver program was developed to provide services to aged and disabled Kentucky residents aged sixty (60) and older, who, but for the provision of such services, would require nursing facility care. These individuals must meet nursing facility level of care requirements and technical and financial requirements for Kentucky's Medical Assistance Program. The Homecare waiver program allows adults who are unable to perform some activities of daily living and are at risk of institutional care to remain in their own homes by providing supportive services and coordinating the help of family, friends, and provider agencies. Homecare services are not available to individuals who are inpatients of a hospital, nursing facility or ICF/MR.

SUPPORTS FOR COMMUNITY LIVING

The Supports for Community Living (SCL) waiver program was developed to serve Kentucky residents as an alternative to institutional care for an individual with mental retardation or developmental disability. These individuals must meet the level of care criteria for placement in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) and whose services in an ICF/MR would qualify for payment under the State Plan for Medical Assistance. This program is designed to allow an individual to remain in or return to the community in the least restrictive setting. SCL services are not available to an individual while an inpatient of a hospital,

nursing facility or ICF/MR.

ACQUIRED BRAIN INJURY WAIVER

The Acquired Brain Injury (ABI) waiver was developed to serve Kentucky residents age twenty-one (21) to sixty-five (65) who have an acquired brain injury. These individuals shall be receiving inpatient services in a nursing facility (NF), or a nursing facility/brain injury (NF/BI) program, or who are in the community and have the potential for inpatient services in a NF or NF/BI program. These individuals shall meet the level of care criteria for placement in a NF and whose services in an NF would qualify for payment under the State Plan for Medical Assistance. The goal of the ABI waiver program is to rehabilitate and reintegrate individuals with an acquired brain injury into the community with the availability of existing community resources when discharged from the ABI waiver program. These services are not available to individuals who have congenital brain injuries.

F. Hospice

For those residents enrolled in the Medicaid Hospice Program, charges for all services provided in a nursing facility shall be billed directly to the hospice agency responsible for the resident's care. Questions regarding hospice benefits shall be directed to the Department for Medicaid Services, Division of Long Term Care and Community Alternatives, 275 East Main Street, Frankfort, Kentucky 40621.

KENTUCKY MEDICAID PROGRAM
NURSING FACILITY SERVICES MANUAL

SECTION IV-A NURSING FACILITY BRAIN INJURY PROGRAM

SECTION IV - A - NURSING FACILITY BRAIN INJURY PROGRAM

IV-A. NURSING FACILITY BRAIN INJURY PROGRAM

A. Scope of Benefits

Medicaid reimbursement for specialized physical rehabilitation services shall be available to nursing facilities that meet the requirements, and participate in the nursing facility brain injury aspect of the nursing facility element of the Medicaid Program. Nursing facilities with a Medicaid waiver for the nurse-staffing requirement are not eligible to participate in the Brain Injury Program.

A brain injury program provides categorical and goal directed services to persons principally with a primary diagnosis of traumatically acquired brain damage that results in residual deficits and disability. Inclusion of other cerebral disorders shall be based on age, disability profiles and rehabilitation potential and service needs.

The brain injury program is not intended to function as a stroke rehabilitation program, although some persons with a cerebral vascular accident may be served.

1. Injuries within the Scope of Benefits

Following is a list of injuries that may be included in the Medicaid brain injury program scope of benefits.

(a) Central Nervous System (CNS) injury from physical trauma;
(b) CNS damage from anoxia/hypoxic episodes; and
(c) CNS damage from allergic conditions, toxic substances and other acute medical/clinical incidents.

2. Exclusions from Scope of Benefits

Excluded from scope of benefits shall be:

(a) Strokes; (NOTE: Nursing facilities provide rehabilitation services expected to meet the needs of most stroke patients.)
(b) Spinal cord injuries in which there are no known or obvious injuries to the intracranial CNS;

(c) Progressive dementia's and other mentally impairing conditions;
(d) Depression and psychiatric disorders in which there is not known or obvious CNS damage;
(e) Mental retardation, developmental disabilities and birth defect related disorders of long standing; and
(f) Neurological degenerative, metabolic and other medical conditions of a chronic, degenerative nature.

B. Admission and Continued-Stay Reviews to Authorize Medicaid Reimbursement.

The admission and continued stay reviews to authorize Medicaid reimbursement for the Nursing Facility Brain Injury Program shall consist of a two step process.

The first step involves the Kentucky Medicaid approved PRO and the nursing facility level of care determination. The Kentucky Medicaid approved PRO shall have responsibility for the skilled nursing facility level of care determination aspect of the admission and continued stay reviews. This determination is made for persons requesting Nursing Facility Brain Injury Program services as determined by the Medicaid Program using the skilled level of care criteria and in the same manner as it is done for persons requesting placement in a non-special-purpose Medicare and Medicaid nursing facility bed. If it appears that the individual requires rehabilitation services over and above those which are available in a non-special-purpose Medicare and Medicaid certified nursing facility, and Nursing Facility Brain Injury Program services are requested, the admission review shall be coordinated with the Department for Medicaid Services (DMS).

The second step is for the purpose of determining if the individual requires specialized rehabilitation over and above that which is available in a Medicare and Medicaid certified nursing facility.The authorization of Medicaid reimbursement for Nursing facility brain injury program services shall be made by the Department for Medicaid Services in conjunction with the admission and continued stay reviews that are conducted by the PRO. This authorization of Medicaid reimbursement for nursing facility brain injury program services by Medicaid shall be granted prior to admission to the

brain injury unit, or if the individual was already admitted to the unit with other third party coverage, the Medicaid authorization shall be granted prior to the exhaustion of those benefits.

The authorization shall be granted by Medicaid based upon the comprehensive evaluation and proposed plan of care performed and developed by the Nursing facility brain injury program. The following is taken into consideration.

1. Indications for Brain Injury Program

Indications for admission and continued stay are as follows:

(a) The individual sustained a traumatic brain injury with structural, non-degenerative brain damage and is medically stable;

(b) The individual is not in a persistent vegetative state; (Persistent vegetative state is defined as a condition in which the individual opens his or her eyes but does not focus on anything, utters no intelligible sound and makes no meaningful responses to any kind of stimulus. Many patients go through this state when emerging from a coma but do not necessarily remain permanently in this condition.);

(c) The individual demonstrates physical, behavioral and cognitive rehabilitation potential;

(d) The individual requires coma management; and

(e) The individual has sustained diffuse brain damage caused by:

(1) Anoxia;

(2) Toxic poisoning; or

(3) CVA (condition necessitates specialized

(4) rehabilitation and the individual has rehabilitation potential; or encephalitis).

2. Basis of Brain Injury Program Level of Care Determination

The determination by Medicaid shall be based upon the following:

(a) The presenting problem(s);

(b) The goals and expected benefits of the admission;

(c) The initial estimated time frames for goal accomplishment; and
(d) The services needed.

The continued stay review by the PRO shall be conducted in the same manner and at the same frequency as it is conducted for Medicaid residents occupying non-special-purpose Medicare and Medicaid certified facility beds (i.e., at the end of the initial length of stay which can be up to thirty (30) days, and at least every ninety (90) days thereafter).
The initial authorization by Medicaid for Nursing facility brain injury program benefits may be made for a period of three (3) to six (6) months (subject to continued review); however, should the individual's health status and care needs, at some point during the authorized period, not be within the scope of skilled NF benfits, as determined by the Medicaid Program, he or she would no longer be eligible for Nursing facility brain injury program benefits. The Nursing facility brain injury program shall forward to Medicaid a monthly progress report for each resident for on-going review and monitoring and consideration for continued eligibility for Nursing facility brain injury program benefits. Coverage shall be discontinued when it is determined that the individual no longer requires specialized rehabilitation services over and above those which are available in a non-special-purpose Medicare and Medicaid certified nursing facility.

C. Provider Participation Requirements

1. Designation of Beds

Medicare certified nursing facilities that wish to participate as a provider of specialized rehabilitation services for brain-injured individuals in the Kentucky Medicaid program shall designate at least ten (10) Medicare certified, physically identifiable, contiguous beds, for the delivery of inpatient specialized physical rehabilitation services. The designated unit shall be organized, staffed and equipped for the specific purpose of providing a rehabilitation program. Medicaid reimbursement for services provided to residents

occupying these beds shall only be made for brain injury program services. Further, the continued certification of these beds for the brain injury program shall be contingent upon the use of the beds solely for the brain injury program regardless of source of payment.

The nursing facility shall comply with the Conditions for Participation in the Federal Medicare Program and Kentucky's Medicaid Program for all certified beds including the beds designated and Medicaid-certified for the provision of inpatient specialized physical rehabilitation services. Furthermore, in order to be eligible for certification to participate in the Medicaid Nursing Facility Brain Injury Program, the facility shall meet additional requirements.

If the Nursing facility brain injury unit is physically located in the plant of a licensed comprehensive physical rehabilitation hospital or a licensed acute care hospital for rehabilitation services, the Nursing Facility Brain Injury Program shall not be required to duplicate the following requirements in order to meet the additional requirements herein outlined; however, the Nursing facility brain injury unit shall be clearly included.

(a) Administration and Operation Policies
(b) Governing Authority
(c) Quality Assurance and Program Evaluation

2. Accreditation

To continue participation in the Kentucky Medicaid Nursing Facility Brain Injury Program after the first year of Kentucky Medicaid participation, the facility or unit shall be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF).

D. Additional Requirements

The additional requirements for participation in the Medicaid Nursing facility brain injury program are as follows:

SECTION IV - A - NURSING FACILITY BRAIN INJURY PROGRAM

1. Administration and Operation Policies

The facility shall have written policies and procedures governing all aspects of the operation and provision of specialized inpatient physical rehabilitation services which include as written:

(a) Admission statement of the specialized inpatient physical rehabilitation services it shall offer and it shall be made available to the general public upon request;

(b) Program narrative which describes in detail the rehabilitation problems and conditions for which the facility provides services, the delivery of the services and the goals of treatment;

(c) Description of the organizational structure of the physical rehabilitation unit including lines of authority, responsibility and communication and department or unit organization;

(d) Description of its program design;

(e) Admission policies that assure the admission of persons whose conditions and rehabilitation needs necessitate specialized rehabilitation services over and above that provided in a non-special-purpose Medicare and Medicaid certified nursing facility unit;

(f) Policies that provide for the maintenance of records of persons ineligible for admission at least two (2) years, including the reason and referral action;

(g) Policy that requires that all patients shall have a history and assessment interview within seventy-two (72) hours after admission for rehabilitation entered into the patient record which includes:

(1) A determination of behavioral and cognitive functioning;
(2) Vocational history;
(3) Familial relationships;
(4) Educational background;
(5) Social support system; and
(6) A determination that the patient can benefit from a rehabilitation program through the use of therapies provided by the institution.

2. Governing Authority

The governing authority means the individual, agency, partnership or corporation, in which the ultimate responsibility and authority for the conduct of the facility are vested.

The governing authority shall
(a) Provide effective and ethical leadership;
(b) Have the responsibility for the maintenance of high standards for the brain injury program; and
(c) Conduct a periodic, systematic assessment of its brain injury program.

If the brain injury unit is located in a free-standing or a general hospital-based nursing facility (i.e., is not attached to an acute care hospital that is licensed specifically for rehabilitation services or a licensed comprehensive physical rehabilitation hospital) the governing authority shall have a written contractual arrangement for the provision of active and regular consultation in the provision of high quality Specialized physical rehabilitation for persons with brain injuries. This consultation shall be at a frequency sufficient to ensure the provision of high quality specialized services and be documented in writing at least every thirty (30) days.

3. Quality Assurance and Program Evaluation

There shall be a planned and systematic process for monitoring and evaluating the quality and appropriateness of patient care and services and for resolving identified problems. This process shall include input from both professional and administrative staffs regarding the character of the head injury caseload and program effectiveness.
(a) The quality and appropriateness of patient care shall be monitored and evaluated in all major clinical functions of the comprehensive physical rehabilitation program. Monitoring and evaluating shall be accomplished through the following means:

(1) Routine collection of information about important aspects of rehabilitation care; and

(2) Periodic assessments of the collected information in order to identify important problems in patient care and opportunities to improve care. Objective criteria shall be established and applied that reflect current knowledge and clinic experience concerning the services offered by the institution.

(b) The program evaluation shall involve at least a sampling of persons served, including persons discharged and shall be conducted quarterly.

(c) When important problems in patient care or opportunities to improve care are identified;

(d) The findings from the conclusions of monitoring, evaluating, and problem-solving activities and the actions taken to resolve problems and improve patient care, and information about the impact of the actions taken, shall be documented and shall be reported to the governing authority and appropriate committees, and made available to the Cabinet for Health and Family Services upon request.

(e) If an outside source(s) provides rehabilitation services, the quality and appropriateness of patient care provided shall be monitored and evaluated, and identified problems resolved.

4. Service Requirements

The nursing facility shall offer a planned combination of comprehensive, specialized inpatient rehabilitation services. A planned program of comprehensive rehabilitation services is a program of coordinated and integrated services which include evaluation and treatment and emphasizes education and training of those served and their families.

The program is composed of medical, nursing, therapeutic, restorative, psychosocial, vocational and educational services which enable an individual with an injury to function at his maximum potential. While vocational and educational

services are essential components to the individual's overall rehabilitation, Medicaid does not provide reimbursement for these services. The Kentucky Department of Education is a possible resource for funding some of these services.

Comprehensive physical rehabilitation programs offer a wide range of therapeutic services provided by registered, certified, licensed or degreed professionals, who utilize an interdisciplinary, goal oriented, team approach with treatment plans designed for the individual patient needs.

5. Program Design

The program shall target medically stable, traumatic brain injured individuals with an expected length of stay of three (3) to twelve (12) months. The goal oriented program shall provide an individualized planned and coordinated program for specialized physical rehabilitation services in accordance with the plan of treatment developed by an interdisciplinary team. The plan shall be directed at restoring the individual to his optimal level of physical, cognitive and behavioral functioning.

(a) There shall be an individual designated with the administrative responsibility and qualifications for the head injury program as follows:
   (1) The program director shall have two (2) years clinical or administrative experience in traumatic brain injury programs;
   (2) Provide direction and oversight of the program;
   (3) Provide ongoing review and implement changes as needed; and
   (4) Assure the development and implement of educational programs for staff on an ongoing basis.

(b) There shall be an individual designated with the responsibility for the service delivery of the head injury program.

(c) Designated treatment space shall be provided, including distraction-free areas for all treating disciplines.

(d) There shall be sufficient space, equipment, and facilities to support clinical, education and administrative functions of the program.

(e) There shall be provisions for ensuring a safe and secure environment consistent with the behavioral and cognitive limitations of brain-injured individuals. This includes trained staff to deal with crisis and physical intervention procedures to secure patient and good staff safety and alarm systems such as those used on beds, rooms, wheelchairs, and on exit doors. Mechanical restraints may at times be necessary to maintain patient safety and shall be used in accordance with state and federal regulations and facility policy.

(f) The facility shall not admit or retain individuals who are dangerous to themselves or others to the extent that the health, welfare and safety of the individual, other patients and staff cannot be insured.

(g) The formally organized program shall provide for support and the offering of counseling to families and patients.

(h) The program shall have a formalized mechanism for ongoing evaluation of alternative service settings appropriate to the neurological and psychological needs of individuals served and their families and the frequency and intensity of services needed.

(i) The program shall have an established process for coordination with relevant public and community agencies including, but not limited to, vocational rehabilitation, education, mental health, developmental disabilities, Social Security, Department for Social Insurance, etc.

(j) The brain injury program shall have appropriate services to manage the functional, psychosocial, and medical needs of those served.

(k) There shall be appropriate psychosocial intervention from admission through discharge in order to meet the needs of those served.

(l) The scope and intensity of medical services shall relate to the persons' medical care needs in order to safely provide a comprehensive rehabilitation

program. There shall be ready availability of these medical services, either within the facility or by linkages with other agencies and individuals.

(m) The scope and intensity of rehabilitation services shall relate to the disability and to the individual's response to treatment.

(n) Services shall be provided by a coordinated, interdisciplinary team.

(1) The team shall be the major decision-making body in determining the goals, process and time frames for accomplishment of each person's rehabilitation program.

(2) The team shall be composed of the treating members of each discipline essential to the person's accomplishment of the goals and expected benefits of the admission.

(3) The team shall meet on a formalized basis at a frequency necessary to carry out their decision-making responsibilities. A team conference shall occur for each person served no less than every other week. There should be an interim informal conference among the members of the team.

(o) There shall be a written plan of follow-up care. The brain injury program shall provide for follow-up care when this is appropriate for those people who remain in its service area. Arrangements to facilitate follow-up care shall be made for those who will leave the program's geographic service area. The follow-up plan shall provide for:

(1) Referral and forwarding of clinical information to a designated physician and service program.

(2) Provisions for reevaluation of status as appropriate and feasible.

(3) Specific recommendations for medical, neurological, physical, cognitive, behavioral, vocational, educational, psychological, and family management.

(4) Designation of an individual responsible for case management after discharge to assure

continuity and coordination of post discharge services.

(5) Identification of an individual within the receiving community who will be responsible for case management after discharge to assure continuity and coordination of post discharge services.

6. Rehabilitation Treatment Plan

(a) The treatment plan shall have been developed by the interdisciplinary team and based on an integrated assessment. The initial plan shall be developed within fourteen (l4) days of admission and reviewed and revised at least every fourteen (14) days thereafter. The following shall be assessed during the initial and on-going assessments:

(1) Medical and neurological issues;
(2) Health and nutrition;
(3) Sensorimotor capacity including gross and fine motor strength and control, sensation, balance, joint range of motion, mobility and function;
(4) Cognitive capacity;
(5) Perpetual capacity;
(6) Communicative capacity;
(7) Affect and mood;
(8) Interpersonal and social skills;
(9) Behavior;
(10) Activities of daily living including self-care, home and community skills;
(11) Recreation and leisure time skills;
(12) Educational and vocational capacities:
(13) Sexuality;
(14) Family;
(15) Legal competency of the person;
(16) Community reintegration, including appropriate post-discharge services;
(17) Environmental modification;
(18) Adjustment to disability, and
(19) All other areas deemed relevant for the person;

(b) The treatment plan shall include:

(1) Identification of the patient's rehabilitation goals stated in functional and behavioral objectives relative to the performance of life tasks and capabilities, with criteria for termination of treatment or discharge from the program;

(2) Participation of the patient and his family, to the extent possible;

(3) Physician input relative to both the general medical and rehabilitation medical needs of the patient;

(4) Discharge planning addressed as part of goal setting as early as possible in the rehabilitation process;

(5) Time intervals at which treatment or service outcomes will be reviewed;

(6) Anticipated time frame(s) for the accomplishment of individual's specified goals;

(7) The measures to be used to assess the effects of treatment or services; and

(8) The person(s) responsible for implementation of the plan.

7. Staff Requirements

The program shall have adequate personnel to meet the needs of patients on a twenty-four (24) hour basis. The number and classification of personnel required shall be based on the number of patients and the individual treatment plans. The following staffing requirements shall be considered separate from any remaining beds in the facility.

(a) Medical Staff Services

(1) Medical management shall be provided under the direction of a physician who has advanced training and experience in traumatic brain injury rehabilitation.

(2) Physician services shall be available twenty-four (24) hours a day on at least an on-call basis.

(3) There shall be sufficient medical staff coverage for services provided in the institution in keeping with the size of the institution, the scope of services provided and the types of patients admitted to the facility.

(4) An individual rehabilitation program plan shall be developed for each patient under the supervision of a physician. The attending physician shall attend and actively participate in conferences concerning those served.

(5) The attending physician shall complete the discharge summary and sign the records within fifteen (15) days of discharge.

(6) The physician responsible for the patient's rehabilitation program shall have specialized training or experience in rehabilitation.

(7) There shall be direct individual contact by a physician at least three (3)times per week; however, more frequent physician visits shall be made if the individual's medical condition warrants.

(b) Nursing Services

These services provide prevention of complications of disability, restoration of optimal functioning, and adaptation to an altered lifestyle through the use of the nursing process (assessment, planning, intervention, and evaluation).

(1) The facility or unit shall have a nursing department and nursing staff organized to provide basic nursing services as well as rehabilitation nursing services.

(2) A registered nurse with training and experience in rehabilitative nursing shall serve as charge nurse of the unit and director of the nursing department.

(3) There shall be a registered nurse on duty on the Nursing facility brain injury program unit at all times.

a) There shall be registered nurse supervision of nursing staff personnel on a twenty-four (24) hour basis to ensure immediate availability of a registered nurse with rehabilitation experience for all patients.
b) There shall be other nursing personnel on the unit in sufficient numbers to provide nursing care not requiring the services of a registered nurse.
c) Nursing care shall be documented on each shift by persons providing care to patients. This documentation shall describe the nursing care provided and include information and observations of significance which contribute to the continuity of patient care.

(4) Rehabilitation of nursing services shall include physical and psychosocial assessment of function of the following:
a) All body systems related to the patient's physical rehabilitation nursing needs, with special emphasis on skin integrity, bowel and bladder function, and respiratory and
circulatory systems function;
b) Self-care skills development;
c) Interpersonal relationships;
d) Adaptation mechanisms and patterns used to manage stress, and
e) Sleep and rest patterns.

5) Nursing services shall also include the following interventions:
a) Health maintenance and discharge teaching;
b) Prevention of the complications of immobility;
c) Physical care including hygiene, skin care, physical transfer from one place to

another, positioning and bowel and bladder care;

d) Psychosocial services including socialization, adaptation to an altered lifestyle; and

e) Reinforcement of the interdisciplinary treatment plan.

(6) As appropriate, nurses collaborate with the patient, family, other disciplines and agencies in discharge planning and teaching.

(7) Rehabilitation nursing shall monitor the degree of achievement of individualized nursing patient care goals.

(c) Interdisciplinary Team

There shall be an interdisciplinary team responsible for developing the individual treatment plans, discharge plans and conducting the quality assurance reviews. The interdisciplinary team shall include a physician, rehabilitation nurse, social workers, or psychologist, and those therapists involved in the patient's care. At a minimum, a team shall include a physician, rehabilitation nurse and two (2) therapists.

(d) Program Manager

(1) A single program manager shall be designated for each patient served. The provision of services to each patient shall be organized through the patient's program manager. The program manager shall:

a) Assume responsibility for the patient during the course of treatment;

b) Coordinate the treatment plan; and

c) Cultivate the patient's participation in the program.

(2) The patient's program manager shall evaluate regularly the appropriateness of the treatment plan in relation to the progress of the patient toward the attainment of stated goals. The program manager shall assure that:

a) The person is adequately oriented;

b) The plan proceeds in an orderly, purposeful, and timely manner; and

c) The discharge decision and arrangement for follow-up are properly made.

(e) Therapeutic Services

(1) In addition to physician and nursing services, the facility shall provide the following allied services directly or under contract. These services shall be provided at an intensity appropriate to the disability and to the patient's response to treatment with a minimum average level for three (3) to five *(5)* hours of therapeutic service per person per day at least five (5) days per week. Therapeutic services consist of treatment and rehabilitation services that involve the patient's participation and do not include services that are performed on behalf of the patient. Services shall be delivered by the appropriate registered, certified, licensed and degreed personnel or be performed substantially in their presence.

(2) Occupational therapy services shall be provided by or under the supervision of an individual certified by the American Occupational Therapy Association as an occupational therapist. Services shall include:

a) Assessment and treatment of functional performance; independent living skills; prevocational and work adjustment skills; educational, play and leisure and social skills.

b) Assessment and treatment of performance components and neuromuscular, sensor integrative, cognitive and psycho-social skills.

c) Therapeutic interventions, adaptations, and prevention.

d) Individualized evaluations of past and current performance shall be achieved through observation of individual or group tasks, standardized test, record review, interviews, or activity histories.

e) Assess architectural barriers in home and workplace, and recommend equipment, adaptations, and different arrangements.

f) Treatment goals shall be achieved through use of selected modalities and techniques which include:

1.) Tasks oriented activities; simulation or actual practice or work, self-care, home management, leisure and social skills and their components, creative media, games, computers and other equipment.

2.) Pre-vocational training;

3.) Sensor motor activities;

4.) Patient and family education and counseling;

5.) Design, fabrication and application of orthotic devices;

6.) Guidance in use of adaptive equipment and prosthetic devices;

7.) Adaptation to physical and social environment, and use of therapeutic milieu;

8.) Joint protection and body mechanics;

9.) Positioning;

10.) Work simplification and energy conservation;
11.) Cognitive remediation; and
12.) Dysphasia evaluation and retraining.

g) The occupational therapist shall monitor the extent to which the goals are met relative to assessing and increasing patient's functional abilities in daily living skills.

(3) Physical therapy services shall be provided by or under the supervision of a licensed physical therapist with additional training and experience in neurodevelopment techniques.

a) Services shall include the following:
1.) An initial physical therapy evaluation and assessment of the patient prior to the provision of services
2.) Development of treatment goals and plans in accordance with the initial evaluation findings with treatment aimed at preventing or reducing disability or pain, and restoring lost function;
3.) Therapeutic interventions which focus on posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, and restoring loss of function.

b) The physical therapist shall monitor the extent to which services have met therapeutic goals relative to the initial and all subsequent examinations, and the degree to which improvement occurs relative to the identified movement dysfunction or reduction of pain associated with movement.

(4) Psychological services shall be provided by or under the supervision of a licensed psychologist.
   a) Assessment areas shall include psychological and neuro-psychological functioning.
   b) Interventions include individual and group psycho-therapy, family consultation and therapy; and design of such specialized psychological intervention programs as behavior modification, behavioral treatment regimens' patients, and the use of biofeedback and relaxation procedures.
   c) The psychologist shall monitor the cognitive and emotional adaptation of the patient and family to the patient's disability.

(5) Speech-language services shall be provided by or under the supervision of a licensed speech-language pathologist who meets the standards for the Certificate of Clinical Competency by the American Speech-Language, and Hearing Association. Services shall include:
   a) Screening to identify individuals who require further evaluation to determine the presence or absence of a communicative disorder and the presence of a swallowing disorder.
   b) When the speech and language competencies of individuals are evaluated, the pathologist plans, directs, and conducts habilitative, rehabilitative, and counseling programs to improve language, voice, cognitive linguistic skills, articulation, fluency, and adjustment to hearing loss, and assesses and provides alternative and augmentative communicative devices.
   c) Plans for discharge and provides for the patient's understanding of communication abilities and prognosis.
   d) Services are monitored for effectiveness of actions taken to improve communication skills of patients.

(f) Other Services

The following services shall be provided directly or through a contractual arrangement with other providers as needed in accordance with the facility's brain injury program narrative:

(1) Social work services shall be provided by an individual with a master's degree in social work from a curriculum accredited by the Council for Social Work Education.

a) The scope of rehabilitation social services shall include the following areas related to work assessment and interventions to facilitate rehabilitation:

1.) Assessment of the personal history and current psychosocial adaptation to the disability;

2.) Assessment of immediate and extended family and other support persons relative to increasing support networks;

3.) Assessment of housing, living arrangements, and stability and source of income relative to facilitating discharge plans; and

b) Intervention strategies, aimed at increasing effectiveness of coping, strengthening informal support systems, and facilitating continuity of care, shall include at least the following:

1.) Discharge planning activities;

2.) Casework with individual patients;

3.) Family counseling and therapy;

4.) Group work focused on both education and therapy; and

5.) Community service linkage and referrals.

c) The person responsible for social services shall monitor the achievement of goals relative to discharge planning activities designed to meet the basis

sustenance, shelter, and comfort needs of patients and their families.

(2) Audiology services provided by or under the supervision of a licensed audiologist, and certified by the American Speech-Language, and Health Association. When the range, nature, and degree of the patient's auditory and vestibular function using instrumentation such as audiometers, eletroacoustic equipment and electro-nystagmographic equipment are determined, the professional plan directs and conducts aural habilitation and rehabilitation programs. These shall include:

a) Hearing aid and assistive listening device selection and orientation;
b) Counseling, guidance and auditory training; and
c) Speech reading

(3) Vocational and vocational rehabilitation services. These services provide assessment and evaluation to the individual's need for services to enable to return to productive activity through the use of testing, counseling, and other service related activities. These identified needs are met either directly or through appropriate referrals. Services shall include:

a) Evaluation and assessment focusing on maximizing the independent productive functioning of the individual; and
b) Comprehensive services shall include, at a minimum, the following areas:
    1.) Physical and intellectual capacity evaluation;
    2.) Interest and attitudes;
    3.) Emotional and social adjustment;
    4.) Work skills and capabilities;
    5.) Vocational potential and objectives; and
    6.) Job analysis.

c) Appropriate instruments, equipment and methods, under supervision of a qualified therapist shall be used.
d) A written report with interpretation and recommendations shall be prepared and shared with the individual and referral source.
e) Services shall monitor the degree to which appropriate work skills are achieved, the improvement in independent functioning relative to work skill capability; and, the achievement or vocational objectives.

(4) Prosthetic and orthotic services shall be provided by authorized specialists who are qualified to manage the orthotic (prosthetic) needs of disabled persons by performing an examination; by participating in the prescribing of needed specialized equipment; by designing and fitting the equipment; and by following up to ensure that the equipment is properly functioning and fitting.

Monitoring of prosthetics and orthotic services shall include:
a) Documented evidence or communication with the prosthetist relative to function and fit of the equipment.
b) Patient satisfaction with the orthosis or prosthesis relative to function and fit of the equipment.

(5) Therapeutic recreation services shall be provided by or under the supervision of a therapeutic recreation specialist, or under the supervision of an occupational therapist. These services may be provided in conjunction with occupational therapy services. Services shall include the following:

a) Assessment of the patient's leisure, social and recreational abilities, deficiencies, interests, barriers, life experiences, needs, and potential;
b) Treatment services designed to improve social, emotional, cognitive, and

physical functional behaviors as a necessary prerequisite to future leisure and social involvement;

c) Leisure education designed to help the patient acquire knowledge, skills and attitudes needed for independent leisure and social involvement, community adjustment, responsible decision-making, and use of free time; and

d) Monitoring which measures the extent to which goals are achieved relative to the use of leisure time and socialization skills.

(6) Respiratory therapy services shall be provided as medically indicated in accordance with written physician orders.

8. In-service Training

The facility shall have a planned program for ongoing in-service training at least quarterly for all staff with emphasis on the service and rehabilitation needs unique to individuals who have sustained brain injuries. The training shall also include topics such as infection control, medical and other emergencies, mobility training, etc.

KENTUCKY MEDICAID PROGRAM
NURSING FACILITY SERVICES MANUAL

SECTION IV-B DISTINCT PART VENTILATOR NURSING FACILITY PROGRAM

IV-B. DISTINCT PART VENTILATOR NURSING FACILITIES

Individuals who are ventilator dependent and meet usual skilled nursing facility level of care criteria may be provided care in a certified distinct part ventilator nursing facility unit providing specialized ventilator services if the care is preauthorized using criteria specified in this Section of the Nursing Facilities Services Manual.

A. Facility Participation Criteria shall be:

1. The nursing facility shall operate a program of ventilator care within a certified distinct part nursing facility which meets the needs of all ventilator patients admitted to the unit.

2. The unit shall have not less than twenty (20) beds certified for the provision of ventilator care.

3. The unit shall be required to have an average patient census of not less than fifteen (15) patients during the calendar quarter preceding the beginning of the facility's rate year or the quarter for which certification is being granted in order to qualify for distinct part ventilator nursing facility certification.

4. The unit shall have a ventilator machine owned by the facility for each certified bed with an additional back up ventilator machine required for every ten (10) beds.

5. The facility shall have an appropriate program for discharge planning and weaning from the ventilator.

B. Patient Criteria and Service Characteristics

The following describe general patient criteria and treatment characteristics for distinct part ventilator nursing facilities:

1. The individual shall be ventilator (or respiration stimulating mechanism) dependent for twenty-four (24) hours perday and requiring twenty-four (24) hours per day skilled specialty nursing care;

2. The individual shall be ventilator (or respiration stimulating mechanism) dependent for twelve (12) hours or more per day during a weaning program with the goal to attain the least mechanical support in the least invasive manner that is consistent with maximal function of the individual and requiring twenty-four (24) hours per day skilled specialty nursing care;

3. Admissions from hospitalization or other locations should demonstrate two (2) weeks clinical and physiologic stability including applicable weaning attempts prior to transfer; and

4. As a practical matter, the services cannot be provided in an appropriate alternative setting to meet the medical stability and safety needs of the individual.

C. Nursing Facility Level of Care determinations shall be made taking into consideration the following factors:

1. Alternative care possibilities;

2. Goals for patient care;

3. Primary hypoventilation, restrictive lung, ventilatory muscle dysfunction, and obstructive airway disorder needs which may necessitate ventilator and related care;

4. Non-hospital management factors and needs;

5. Patient treatment characteristics;

6. Home care potential;

7. Suitability of transfer to the ventilator care unit;

8. Provision of an appropriate place of care; and

9. Other facility admission indicators as shown in this manual.

D. The following criteria shall be considered in determining Nursing Facility Level of Care for ventilator dependent individuals.

1. Alternative care considerations shall include:

(a) Disease and benefits of ventilator care on a continuing basis;
(b) Patient and family desire;
(c) Ability to manage at home; and
(d) Available resources and required technologies.

2. Goals for patient care shall include:

(a) Extended and enhanced quality of life;
(b) Enhancement of individual potential;
(c) Minimal morbidity;
(d) Improved physical and physiologic function; and
(e) Cost-benefit factor.

3. Patient conditions which may benefit from long term mechanical ventilation (LTMV):

(a) Central hypoventilation

(1) Congenital-idiopathic, anatomic Arnold-Chiori with myelomeningocele
(2) Acquired-traumatic, infectious, surgical procedure, cerebrovascular accident (CVA).

(b) Ventilator muscle dysfunction:

(1) Central nervous system (CNS) disease;
(2) Polyneuropathy;
(3) Muscular dystrophy, myopathies; and
(4) Kyphoscoliosis.

(c) Restrictive lung disease: Less benefit achieved, trial to be done in the hospital before commitment to LTMV.

(d) Chronic obstructive airway disease (COPD) (emphysema, chronic obstructive bronchitis, bronchopulmonary dysplasia (BPD) and cystic fibrosis.:

4. Nonhospital management factors shall include:

(a) Physiologic and clinical stability prior to commitment;

(b) Coexistent diseases shall be addressed; and

(c) Patients with intermittent or frequent changes may be suitable candidates for care in a regular nursing facility bed when home care is not clinically suitable.

(d) Alternative methods of treatment to be considered shall include:

(1) Phrenic nerve stimulation (pacer); and
(2) Rocking bed pneumobelt.

5. Characteristics of candidate for LTMV shall include:

(a) Central hypoventilation - cervical trauma;

(b) Multiple failed wean attempts;

(c) Repeated frequent ventilation failure and admission for ventilator support;

(d) Progressive muscular dystrophy (MD) or amyotrophic lateral sclerosis (ALS); and

(e) Documented ventilation is needed to sustain life or to enhance the life quality.

6. Home care candidacy may be appropriate under the following conditions:

(a) Patient desires placement: Decision made when acute problem is stable and patient participates in decision-making process.

(b) Family desires placement of member:

(1) Psychosocial assistance and support is available;
(2) Structured education; and
(3) Safety issues.

(c) Resources available for alternate placement.

(1) Psychosocial:

a) Established psychosocial support system in the home;
b) Depression and fear addressed;
c) Safety and back-up procedures; and
d) Rehabilitation for mobility when feasible.

(2) Family care needs:

a) Respite; and
b) Training in patient care needs.

(3) Environment:

a) Care setting, mobility and safe exiting;
b) Electrical outlets for ventilator, humidification, and suction;
c) Battery rechargeability or generators; and
d) Alarms systems and accessibility.

(d) Necessary medical support and access available for alternate placement.

(e) Necessary technical support available for alternate placement.

7. The criteria for transfer from a hospital or alternate location setting to a distinct part ventilator nursing facility shall be:

(a) Clinical stability;

(b) Physiologic stability;

(c) Comprehensive program for transfer to a distinct part ventilator nursing facility shall include:

(1) Discharge team;
(2) Educational program; and
(3) Rehabilitation program.

(d) Prescription shall include:

(1) Respiratory care plan; and
(2) Management plan.

(e) Focus on optimizing functional ability; and

(f) Prior to discharge to home or other community placement, training in use of equipment to be used in the home.

8. The plan of care shall include:

   (a) Medical condition stabilization;

   (b) Development and evaluation of realistic goals to include self-care techniques;

   (c) Training rehabilitation plan;

   (d) Rehabilitation training for strength and endurance;

   (e) Discharge planning and equipment maintenance; and

   (f) Home care, follow-up and emergency measures.

9. Facility admission indicators shall include:

   (a) Respiratory infections;

   (b) Assessment of the "free time" off the ventilator;

   (c) Absence of adequate caregivers;

   (d) Evaluation of hemoptysis orrespiratory failure; and

   (e) Backup failure.